MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Diat. No. 05916 102

1. PLACE OF DEATH:
County Charles
City or town Doncaster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Over 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Charles
City or town Doncaster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lettie Biggs Barnes
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife Peter Barnes
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
Appx 75	"	"	" hrs. min.

9. Birthplace Charles County, Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business House work
FATHER 12. Name Columbus Jackson
13. Birthplace Maryland
MOTHER 14. Maiden name Eliza Briggs
15. Birthplace Maryland
16. Informant The Neighborhood
Address Doncaster, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25 1946 (month) (day) (year)
Cemetery or crematory Mt. Hope Church
Location Nanjemoy, Md.
18. Funeral director Stanley Penny
Address Mason Springs, Md.
19. June 27 19 46 (Date rec'd by registrar) A. B. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 46 at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 19 46 to June 22 19 46
and that I last saw her alive on May 7 19 46

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to	
Due to	
Other conditions Arthritis Lumbo-Sprain	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Indian Head Md Date signed 6/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

05917

CERTIFICATE OF DEATH

Reg. Dist. No. 101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 4-45

1. PLACE OF DEATH:
County Charles
City or town Maryland Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Her lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Maryland Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Bastain.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Samuel Bastain
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Apr. 23 1873

8. AGE: Years 73 | Months 11 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace Nanjimoy, Charles Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Murphy
13. Birthplace Charles Co Md

MOTHER 14. Maiden name Caroline Murphy
15. Birthplace Charles Co. Md.

16. Informant Saml Bastain
Address Maryland Point Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 1946 (month) (day) (year)
Cemetery or crematory Durham
Location Ironsides, Md.

18. Funeral director Hunt & Ryon
Address Waldorf Md

19. June 6 1946 (Date rec'd by registrar) Mary Lucille Ford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1946 at 1 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ?, 1920, to June 6 1946
and that I last saw her alive on June 4 1946

Immediate cause of death	DURATION
Cardio-renal disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Jos. O. Dickens M.D.
M. D. or other
Address Marbury Md Date signed June 6 46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05918

Reg. Dist. No. 104

1. PLACE OF DEATH:
County: Charles
City or town: Rural (If outside city or town limits, write RURAL and give nearest town) Route 2 Pomonkey
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Stumptownville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John W. Boarman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Josephine Boarman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 25 1863

8. AGE: Years 83 | Months 3 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace: Pomonkey Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: John Boarman
13. Birthplace: Pomonkey Md.

MOTHER
14. Maiden name: Elizabeth Smart
15. Birthplace: Pomonkey Md.

16. Informant: Thomas B. Boarman
Address: 1234 Penn. Ave. S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/24/46 (month) (day) (year)
Cemetery or crematory: Holy Ghost
Location: Issue Md.

18. Funeral director: W. W. Champion Co.
Address: 317 Eleventh St. S.E. D.C.

19. 6-20-1946 (Date rec'd by registrar) William Fred Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-20-1946 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-17-1946 to 6-20-1946 and that I last saw h.. alive on 6-20-1946

Immediate cause of death: Heart Arteriosclerosis — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. R. Hayden, M. D. or other
Address: Waldorf Date signed 6-20-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05919

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: Pomfret

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Pomfret

(If outside city or town limits, write RURAL and give nearest town)

Street No.: —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Thomas Milven Brawner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1945

8. AGE:

Years	Months	Days	If less than one day
	5	24	... hrs. ... min.

9. Birthplace: Waldorf, Charles, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER

12. Name: James Harris Brawner

13. Birthplace: Pomfret, Md.

MOTHER

14. Maiden name: Agnes L. Shorter

15. Birthplace: Billingsley, Md.

16. Informant: Jas. H. Brawner (father)

Address: Pomfret, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-17-46 (month) (day) (year)

Cemetery or crematory: St. Joseph's

Location: Pomfret, Md.

18. Funeral director: Jasper Brawner

Address: Pomfret, Md.

19. 6-17-46 (Date rec'd by registrar) 19... Julia H. Pasey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1946 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1946, to June 16, 1946

and that I last saw him alive on June 14, 1946

Immediate cause of death	DURATION
Infectious diarrhea	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: James L. MacKavanagh, M.D. M. D. or other

Address: La Plata, Md. Date signed 6-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

05920

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles.
City or town: Hilltop.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 94 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Hilltop. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Susie Ellen Ward Brooks.

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife: John Brooks. (2nd husband).
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 12. 1852

8. AGE:

Years	Months	Days	If less than one day
93	6	5	hrs. min.

9. Birthplace: Ironsides, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home.
FATHER 12. Name: John Montgomery
13. Birthplace: Md.
MOTHER 14. Maiden name: Jane Montgomery
15. Birthplace: Md.
16. Informant: Bessie Ward
Address: Hilltop, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21, 1946 (month) (day) (year)
Cemetery or crematory: Zion Baptist Hilltop Cemetery
Location: Hilltop 30 H. N. E. Wash.
18. Funeral director: John T. Stuart-Lawrence B. Montgomery
Address: Washington D.C.
19. June 17 1946 (Date rec'd by registrar) Odey Price (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1946 at 4A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to June 17 1946;
and that I last saw h alive on 19

Immediate cause of death	DURATION
Chronic myocarditis	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Frank G. Swan M. D.
M. D. or other
Address: Indian Head Md. Date signed 6/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05921

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Physicians' Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Faulkner

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Male Infant Burch

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1946

8. AGE: Years | Months | Days | If less than one day ... hrs. 30 min.

9. Birthplace: La Plata, Charles, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Thomas Oakley Burch
13. Birthplace: St. Mary's County, Md.

MOTHER
14. Maiden name: Frances Ruth Quade
15. Birthplace: St. Marys' County, Md.

16. Informant: Thomas Oakley Burch
Address: Faulkner, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-46 (month) (day) (year)

Cemetery or crematory: Farm

Location: Faulkner, Maryland

18. Funeral director: Thomas Oakley Burch
Address: Faulkner, Md.

19. 6/12/46 (Date rec'd by registrar) Julia A. Passey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12 1946, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h.i.m alive on 6-12-46 19

Immediate cause of death: Suffocation — DURATION 6-12-46

Due to: Aspirated amniotic fluid

Due to: Precipitate labor en-route to hosp

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other

Address: La Plata Md Date signed 6-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05922 105

Reg. Dist. No. ....

1. PLACE OF DEATH:
County: Charles
City or town: Port Tobacco, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Port Tobacco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Jefferson Coulby

3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, Married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Katherine Coulby
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov. 14, 1864
8. AGE: Years: 81 Months: 9 Days: 10 If less than one day: ... hrs. ... min.
9. Birthplace: Kent Co. Md.
(Town, county, and state)
10. Usual occupation: Farming.
11. Industry or business
FATHER 12. Name: Robert Coulby
13. Birthplace: Md.
MOTHER 14. Maiden name: Maryann Morris
15. Birthplace: Md
16. Informant: Reed H. Straw
Address: Port Tobacco, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/26/46 (month) (day) (year)
Cemetery or crematory: Christ Church
Location: Wayside, Md.
18. Funeral director: Hewett & Ryon
Address: Waldorf, Md.
19. 6-25 1946 M L Mears Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1946, at 5 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946 to June 24 1946
and that I last saw h... alive on June 20 1946

Immediate cause of death	DURATION
Cerebral Apoplexy.	
Due to: Cardio Vascular-renal disease.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George C. Bicknell M.D.
M. D. or other
Address: Marlboro Md. Date signed: June 25 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 5983 104

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jesse R. Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-22-128

8. AGE:

Years	Months	Days	If less than one day
18			..... hrs. ..... min.

9. Birthplace: Newburg, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: William Green
13. Birthplace: Tom Bennett, Md.

MOTHER
14. Maiden name: Mabel Butler
15. Birthplace: Newburg, Md.

16. Informant: Martha White
Address: Waldorf, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-3-46 (month) (day) (year)
Cemetery or crematory: Holy Ghost Church Cemetery
Location: Issue, Md.

18. Funeral director: Hewitt & Bryan
Address: Waldorf

19. 7-30-1946 (Date rec'd by registrar) T. William Frap Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-30-1946, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Accidental	
Truck ran over him	
body crushed & death	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: T. L. Higdon, M. D. or other
Address: Waldorf Date signed: 6-30-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05924

CERTIFICATE OF DEATH

Reg. Dist. No. 124

1. PLACE OF DEATH:
County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George W. Higgs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 9 - 1864

8. AGE: Years	Months	Days	If less than one day
81	7	28	..... hrs. ..... min.

9. Birthplace: Newburg (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: William H. Higgs
13. Birthplace: England

MOTHER
14. Maiden name: Mary M. Marshall
15. Birthplace: Newburg Md.

16. Informant: Chas. E. Reeder
Address: Newburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-4-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Waldorf, Md.

18. Funeral director: Hamilton & Hyde
Address: Waldorf Md.

19. 6-8-1946 (Date rec'd by registrar) T. L. Higdon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-8- 1946, at 9:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-14- 1946, to 6-8- 1946
and that I last saw him alive on 6-6- 1946

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: T. L. Hyde M. D. or other
Address: Waldorf Date signed 6-9-46

M

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-M)

CERTIFICATE OF DEATH

05925

Reg. Dist. No. 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: White Plains md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: Chas
City or town: White Plains MD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Henry Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh	married

6.(b) Name of husband or wife: Martha
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 19 - 1889

8. AGE: Years	Months	Days	If less than one day
56	9	8	..... hrs. ..... min.

9. Birthplace: Chas Co MD
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
18. Informant: Martha Jones
Address: White Plains MD
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-13-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland MD
18. Funeral director: Hewitt & Ryon
Address: Woodbury MD
19. 6-12 (Date rec'd by registrar) 1946 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1946, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....
Immediate cause of death: Coroners Case — DURATION
Carbon Monoxide
Due to: Poisoning — 6-11-46
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 6-11-46
Where did injury occur? White Plains (City or town) Chas (County) md (State)
Injured at home, farm, industry, public place (where?): auto
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Leonardtown md Date signed 6-12-46

05926

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Waldorf Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hannon Ezekiel Robey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 20, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	14	hrs. min.

9. Birthplace: White Plains Md (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business
FATHER 12. Name: Mandeville Robey
13. Birthplace: Chas Co Md
MOTHER 14. Maiden name: Letitia Wiett
15. Birthplace: White Plains Md
16. Informant: Mary J. Robey
Address: Waldorf Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-17-46 (month) (day) (year)
Cemetery or crematory: St Pauls Pmy
Location: Nr Waldorf Md
18. Funeral director: Hurst & Pyon
Address: Waldorf Md
19. 6-15 19 46 M E Mosher
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-14 1946, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Coronary Thrombosis — Coroners Case — DURATION: 6-14-46
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E Fedelen M.D.
M. D. or other
Address: La Plata Md Date signed: 6-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

4505
.56
25 Silver dollars.
1600 Grade.

(5927)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 100

VS A15 (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Charles
City or town: Dentsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Dentsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Annie Charlotte St Clair

3. (b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: William H. St Clair
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 18 1853
8. AGE: Years: 92 Months: 9 Days: 24 If less than one day: ..... hrs. ..... min.
9. Birthplace: Dentsville, Md. (Town, county, and state)
10. Usual occupation: House work
11. Industry or business
FATHER 12. Name: Addison Hancock
13. Birthplace: Chas. Co. Md.
MOTHER 14. Maiden name: Emily Dent
15. Birthplace: Chas. Co. Md.
16. Informant: Marshall St. Clair
Address: Dentsville Md.
17. Burial (Burial, cremation, or removal: Which?) Date thereof 6/15/46 (month) (day) (year)
Cemetery or crematory: Dentsville M.E.
Location: Dentsville, Md.
18. Funeral director: Hewett & Payne
Address: Waldorf, Md.
19. 6/14 (Date rec'd by registrar) 19 46 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1946 at 3 45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1940 to June 17 1946
and that I last saw h.er alive on June 17 1946
Immediate cause of death: General Visceral Failure — DURATION
Due to: Arteriosclerosis 3 Duration, five years
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Edelen M.D. M. D. or other
Address: La Plata Md Date signed 6-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

CERTIFICATE OF DEATH

05928 105

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County CHARLES

City or town B BALTON MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles

City or town Bel alton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WALTER THOMPSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife GRACE L. THOMPSON

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-23-71

8. AGE: Years	Months	Days	If less than one day
74	11	29	..... hrs. ..... min.

9. Birthplace (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name JOHN F. THOMPSON

FATHER 13. Birthplace CHAS COUNTY MD.

MOTHER 14. Maiden name MARTHA A ROBEY

MOTHER 15. Birthplace BELALTON MD.

16. Informant P. N. THOMPSON

Address BELALTON MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/46 (month) (day) (year)

Cemetery or crematory St. Ignatius

Location Bel Kelton, md.

18. Funeral director Hunt & Ryon

Address Waldorf, Md.

19. 6-24 .46 (Date rec'd by registrar) M. L. Morris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1946 at 3.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-3- 1946, to 6-22 1946

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death Chronic Myocarditis	6 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest Spencer Jr M.D.

M. D. or other

Address Belalton Md. Date signed 6-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05929

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred: Physicians' Memorial Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Du Bois Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Josephine Ward

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 4 1864

8. AGE:

Years	Months	Days	If less than one day
76	8	13	..... hrs. ..... min.

9. Birthplace: Charles Co. (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business:
12. FATHER — Name: Joseph Ward
13. FATHER — Birthplace: Charles Co Md
14. MOTHER — Maiden name: Patricia E Johnson
15. MOTHER — Birthplace: St Marys Co Md
16. Informant: W. W. Ward
Address: Charlotte Hall Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-19-46 (month) (day) (year)
Cemetery or crematory: Trinity
Location: Newport Md
18. Funeral director: Elmer M Quade
Address: Hughesville Md
19. 6/18/46 (Date rec'd by registrar) 19 ..... Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1946, at 4 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1946 to June 17 1946 and that I last saw h.e alive on June 17 1946

Immediate cause of death	DURATION
Myocardial Failure	2 days
Due to Carcinoma of the Colon	1 Year
Due to —	
Other conditions Anemia, secondary to carcinoma, senility (Include pregnancy within 3 months of death)	6 days

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis C. Garesa M.D. M. D. or other
Address: Hughesville, Md Date signed: June 17, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING